North Carolina Department of Health and Human Services
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Michael F. Easley, Governor
Carmen Hooker Odom, Secretary

Michael Moseley, Director

November 18, 2005

MEMORANDUM

TO: LME Directors
LME Provider Relations Staff

FROM: Mike Moseley

SUBJECT: Medicare Part D Prescription Drug Coverage—MEMORANDUM #3

We hope that you are becoming familiar with the new Medicare Part D prescription drug assistance program and that you have begun to assist your consumers with applying for assistance with drug plan costs and determining the best Medicare Prescription Drug Plans (PDPs) to meet their individual needs. The next consideration is how to help consumers with the transition prior to January 1st. We are providing some reminder information regarding enrollment as well as new information about the transition process. **Please pass this information along to providers who are serving consumers in your area. Documents referenced will also be available on our website at**: http://www.dhhs.state.nc.us/mhddsas/medicare-d/index.htm.

Reminder about Enrollment
Enrollment in a Part D Prescription Drug Plan began November 15th and continues through December 31st 2005, for an effective date of January 1, 2006. For individuals not meeting the December 31st deadline, the initial enrollment period continues through May 15th, with Medicare drug coverage beginning the month following the month they enroll. Individuals enrolled in Medicare should have already received a publication from the Centers for Medicare and Medicaid Services called "Medicare and You," describing the changes in Medicare including the prescription drug coverage. This publication can be viewed at http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf.

Various information about the plans available in North Carolina and their drug formularies, costs, prior authorization criteria, and other information are available at http://www.cms.hhs.gov/map/map.asp#NC and at http://www.medicare.gov. Tools are available at http://www.medicare.gov/MPCO/Home.asp to assist consumers and individuals in finding a plan to meet their needs, including the Medicare Prescription Drug Plan Finder. However, information about co-pays and management tools such as prior approvals and limits on medications may not be on the Drug Plan Finder. In this case, the information will need to be obtained directly from the Part D Plan. An individual may also call 1-800-MEDICARE or a local SHIIP volunteer in the area to talk to an informed person about the plans. An individual may also visit the SHIIP website at http://www.ncshiip.com/Consumer/Shiip/Documents/Form_PDP05.pdf for steps to comparing Medicare Prescriptions Drug Plans.

Individuals who are dually enrolled in Medicare and Medicaid should have recently received yellow colored letters from CMS notifying them of the plans to which they have been assigned. The letters let dually eligible beneficiaries know the Medicare prescription drug plans in which they will be enrolled if they do not take any action prior to January 1st. [Note: individuals who are newly eligible for Medicaid or who recently met the spend-down requirements may not have received an enrollment letter from CMS.] A copy of the letter is available online at the Division of Medical

Assistance website at http://www.dhhs.state.nc.us/dma/medicare_d/counties.htm. Providers who are assisting consumers to pick Part D plans should ask to see the yellow letter to determine what plan has been assigned. If the plan chosen for an individual does not meet his or her needs, the person may choose a different plan at any time beginning November 15. For more information about any of these processes, please see the previous Memoranda or our website.

Transition Planning

Clinicians should begin reviewing the medications being prescribed for individuals to assess PDPs for appropriate coverage, and perform medical reviews to determine the necessity of the drugs being taken. In the event that a consumer is taking a prescription that is not covered in the formulary of the PDP to which he or she is assigned or plans to enroll, therapeutically appropriate medication alternatives that are in the formularies might be tried, or the physician might assist the consumer to request an exception to the Plan's formulary. It is recommended that physicians prescribe a 30-day or a 90-day supply of needed medications per Medicare regulations and that they are obtained prior to January 1, in the event that there are unforeseen or unresolved issues regarding the medications a person is taking with the PDP chosen. For additional clinical recommendations, please see the attached document "Clinical Preparation for Medicare Part D for Dual Eligible Clients in Your Practice" prepared by Dr. Michael Lancaster, Chief of Clinical Policy for the Division.

For additional information about transition planning, please see the following websites:
http://www.cms.hhs.gov/pdps/transition_process.pdf
http://www.cms.hhs.gov/pdps/qafirstfillforltcresidents-final.pdf

Managing Costs

Many individuals being served through LMEs will either be automatically eligible (dually eligible for Medicare and Medicaid) or apply for and be eligible for help with paying the costs related to Part D Drug Plans. However, there may still be co-pays and other related costs, as well as medications that will not be covered. This will depend to some extent on the plan chosen, including whether or not an expanded plan is chosen. The low income assistance will only pay the cost of the basic benefit. In addition, **individuals who are receiving waiver (CAP-MRDD) services and individuals residing in group homes/adult care homes will be required to make co-pays**; this will be different for them as these individuals have not been required to make co-pays while receiving drug coverage under Medicaid. For people who do not have Medicaid or low income assistance, there is required cost-sharing of deductibles, co-pays, and what is commonly being referred to as the "donut hole" in which the individual pays 100% of the medication costs up to a catastrophic threshold.

LMEs and providers should begin assessing how much money the consumer is going to be paying out-of-pocket for medications and assist the consumer in budgeting or otherwise determining how these costs will be paid. LMEs and providers should also assess the possibility that cost-sharing requirements may prevent some individuals from taking their medications, and should be proactive about ways to help beneficiaries get these expenses paid and/or plan for this possibility for individuals at risk.

I hope that you will find this information helpful. We will continue to advise you of changes or information that you might find useful.

Attachment

cc: Secretary Carmen Hooker Odom
Allen Dobson, MD
Executive Leadership Team
State Facility Directors
Management Leadership Team
Carol Duncan Clayton
Kory Goldsmith
Patrice Roesler
MH Commission Chair
Coalition 2001 Chair
SCFAC Chair

Clinical Preparation for Medicare Part D for Dual Eligible Clients in Your Practice/LME

Medicare Part D coverage begins January 1. Because "dual eligible" patients, those with both Medicare and Medicaid coverage, will lose their Medicaid drug benefit and be enrolled under the new Medicare Prescription Drug Plans (PDPs), it is especially important to plan for the transition of that patient population.

1. Identify all the patients who have dual Medicaid/Medicare (dual eligibles) coverage in your practice. If you are an LME, identify all dual eligibles in your catchment area and notify providers about their status.
2. Develop a plan to counsel each client regarding his assigned drug plan. Training for nurses and doctors on the new drug plans and their rules for prescribing, eligibility, costs to clients of these programs, and support in enrollment in a plan will be available as the programs are identified (www.dhhs.state.nc.us/mhddsas/medicare-d/).
3. Staff should set up appointments for each client with a nurse and/or other designated staff member to assist clients who want help in determining which drug plan would work best for them, potential changes in the costs of their prescriptions, and any complications with medical or behavioral medications (psychiatrists consulted on as needed during this process). The specific information on each plan will be available online through a CMS Drug Plan Finder website currently being developed (http://plancompare.medicare.gov/formularyfinder/selectstate.asp).
4. Psychiatrists should start working now with each client to simplify their medication regime as much as possible and discontinue any medications that might not be absolutely necessary.
5. Psychiatrists should coordinate care with the client's primary care physician to identify ALL medications the client may be taking while determining the best available drug plan.
6. All psychiatrists should plan to authorize 90 days of medication where possible during November and December of 2005. This will allow clients to avoid needing to refill prescriptions during the early part of the transition which starts January 1, 2006. Medicaid will pay for this medication if it is a generic that is on the State Maximum Allowable Cost list or the Federal Upper Limit list. It must be indicated as a maintenance drug and it cannot be a controlled substance. There must also have been a previous 30-day fill of the same medication within the last 6 months. Only one co-pay is collected and only one dispensing fee is paid for the 90-day supply of the medication.
7. Education, communication, and patience will assist this transition to a new drug benefit plan for our clients.

Proposed by:
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